PERSPECTIVE

Incorporating Socioeconomic Factors Into U.S. Health Policy: Addressing The Barriers

Commissions and special reports can get the ball rolling, but success hinges on getting various sectors into the game.

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SEVERAL PAPERS in this issue indicate a strong relationship between health and socioeconomic factors such as income, education, and occupation.[1] Some argue that these factors underlie and are more important than health services or even lifestyles in determining morbidity and mortality.[2]

In trying to explain the link between socioeconomic factors and health, some researchers emphasize the direct impact of poverty and deprivation on living conditions; others focus more on the effects of inequality within a society.[3] There is also evidence that race is inextricably linked to socioeconomic status but also displays an independent effect on health.[4] Various mediators between socioeconomic status and health, not necessarily mutually exclusive, have been examined: the presence or absence of trust and social support at the state or community level, irreversible processes in early childhood, the structure of the workplace, and the biological effect of stress throughout life.[5]

The body of work is growing, and researchers have contributed to an extensive policy agenda that requires action among sectors. Recommendations include health, education, housing, and other services for the neediest; reduction of poverty and creation of a more equal economic environment; investment in young children; improvements in working conditions and benefits; and community support.[6] Implementation of such an agenda is likely to be easier in those countries with economic and social policies that explicitly buffer the market and foster redistribution of resources. Some of these countries—for example, the United Kingdom, Sweden, the Netherlands, France, and New Zealand—incorporate action by social, education, economic, housing, transportation, and/or environmental sectors into their health policy discussions and agendas.[7]

The United States has extensive experience with community efforts that combine health care, education, social services, and economic development.[8] At least one state, Minnesota, has developed a health policy agenda involving other sectors of government.[9] At the national level, public and private agencies fund research on the socioeconomic determinants of health, hold conferences, and publish reports.[10] Healthy People 2010, the process that sets and monitors health objectives for the nation, includes some related fields such as behavior, injury and violence prevention, and environmental quality and has taken the major step of targeting the elimination of health disparities by income and race.[11] But the United States stops short of

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incorporating action by other sectors into its deliberations on health policy—action that might help to achieve the ambitious goals of Healthy People.

In this paper we examine the political, professional, and organizational barriers to intersectoral action in the United States, and we suggest how these barriers might be addressed, based on examples from the literature.

Political Barriers

U.S. decisionmakers often avoid issues of class distinction or ethical choices, preferring to base policy on adherence to market values or on the concept of enlightened self-interest. An appeal to American pragmatism may help to overcome this barrier, incorporating the following steps.

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■ **Show that it doesn't take a revolution.** Social and economic action can be employed to address health problems without massive redistribution of resources. For example, research shows a link between poverty and income inequality, and the 30–60 percent difference in mortality among the fifty U.S. states.[12] But the ten Canadian provinces are all clustered at the "good" end of the U.S. scale, without much overlap. Also, unlike the United States, the correlation in Canada between inequality and mortality does not appear significant.[13]

These differences do not appear to be historical, since two decades ago mortality rates did not vary as greatly between these two countries. Several researchers believe that tax policies and income transfers may be responsible. Without these interventions, 1994 household poverty was nearly the same in Canada (23.9 percent) as in the United States (23.2 percent) and, for comparison, slightly lower in Sweden. After accounting for tax policies and transfers, the United States had 18.9 percent of households in poverty; Canada, 14.5 percent; and Sweden, 3.8 percent.[14]

■ **Include intermediate actions.** In the same vein, socioeconomic factors are thought to influence health in part by affecting neighborhoods where people live and such characteristics as housing, public safety, sanitation, nutrition, and health and social services.[15] Improvements in these sectors are more tangible and may be less threatening to U.S. policymakers than are changes in economic policy, while also improving population health.

■ **Demonstrate cost-effectiveness.** Before acting on the link between socioeconomic factors and health, policymakers want evidence of effectiveness—evidence that is hard to come by because so few social changes are designed with cross-sectoral evaluation in mind. But one study demonstrated that implementation of Social Security in the 1930s was associated with a significant decrease in mortality among the elderly, beyond normal expectations.[16] More studies of this type are needed. Researchers on the socioeconomic determinants of health have much to learn from the science of cost-effectiveness analysis, which has grown more sophisticated in recent years.[17] While many technical problems remain, including the valuing of costs and benefits across sectors, economic thinking is beneficial, and progress can be made through pilot studies, data to justify spending, and incentives for collaboration.[18]

■ **Focus on population segments where economic impact or political interest is greatest.** Theories that the organization of the workplace contributes to the health of workers and thus to competitiveness could be tested by interested firms. If changes in working conditions to lower stress and increase workers' control appropriately are shown to be cost-effective, a powerful argument could be made for more widespread implementation.[19] Child health and development also is of interest not only for humane reasons but because this domain has a pervasive impact, throughout life, on physical and mental health, behavioral adjustment, literacy, and educational achievement.[20]

Professional Barriers

Lack of a strong professional constituency also affects the translation of research into policy. The discipline of public health in the United States lacks the pervasive tradition of social medicine that is present in many European countries. Here, many public health experts seem to prefer the specific yet limited steps of expanding access and improving behavior that are within their own purview. For intersectoral collaboration to succeed, a much larger proportion of the public health constituency must be engaged. There are several ways in which this might be accomplished.

■ **Find common ground with advocates of universal access.** There is a danger that the arguments made by proponents of social and economic action may alienate supporters of universal coverage, who fear that their long-sought-after goal may be undermined. Thus, the logic must be developed carefully. For example, universal access and more equal distribution of health services are necessary but not sufficient to improve health. Access may be especially important to low-income and minority populations.[21] The answer lies not in perpetuating a false dichotomy but rather in recognizing that social policy is complementary with, not antithetical to, health policy.

■ **Make peace with the behaviorists.** Those who favor behavioral interventions have been accused of blaming the victims and ignoring the lack of choices available to the poor. While variations in lifestyle account for less than a quarter of socioeconomic differences in mortality, that quarter can be important.[22] Advocates of socioeconomic determinants and behaviorists can work together on more effective ways of reaching needy populations, limits on the availability of and advertising for alcohol and tobacco, and assuring that poor people are actually able to choose healthier lifestyles.

■ **Build on efforts that start with health.** Studies have shown increased effectiveness from combining social and economic support with medical and behavioral efforts.[23] One possibility is to build on the effectiveness of community health centers, whose major expansion has been proposed by the Bush administration.[24] The community-based pilot programs of the Centers for Disease Control and Prevention (CDC) offer another opportunity for expansion with health as the hub.[25] To reach a more general population, health plans could be encouraged to consider social factors in their role as value purchasers, although their power to act is limited without the participation of other public and private institutions.[26]

Organizational Barriers

Action on the socioeconomic factors influencing health requires collaboration among multiple agencies, congressional committees, and academic disciplines. Health agencies and programs are part of the problem. They and their supporters are frequently organized around separate clinical diseases—the so-called disease-of-the-month club—with separate staffing and budgets. Because evidence shows that many diseases are affected by a similar range of social forces, there is a need for better coordination, cross-cutting policy initiatives, and, in some cases, organization by population group or underlying problem rather than by disease.

A greater problem is that health is influenced by many factors controlled by executive offices (Office of Management and Budget, Council of Economic Advisers) and departments (Labor, Housing and Urban Development, Commerce, Justice, Agriculture, Education, Transportation, and Environmental Protection) not traditionally thought of as health-related. Congressional jurisdictions may be even more complex.

Various mechanisms have been proposed to influence all of these groups and focus on the health impacts of a broad range of policies. Some may be more effective than others.

■ **Conduct health impact assessments.** The European Science Foundation is encouraging countries in that region to assess the health impact of nonhealth policies, a practice that involves many of the same issues as inter-

sectoral cost-effectiveness analysis. One review suggests abandoning health impact assessments that typically assign numerical values despite lack of systematic literature review, data gathering, or consultation. Instead, communities are encouraged to pursue "mini" assessments that increase awareness without attempting to quantify results, and national governments are encouraged to triage potential topics for importance and then conduct rigorous "maxi" assessments on a limited number of issues.[27]

■ **Consider block-grant funding for health and other services.** One Canadian province adopted block-grant funding of health and social services as an incentive for intersectoral reallocation of resources by its regional authorities. While the underlying rhetoric was based on the socioeconomic determinants literature, what little reallocation occurred actually increased funding for hospitals. Reviewers attributed the negative results to a simultaneous reduction in overall funding, the strength and emotional attachment of the health care sector, and lack of a needs-based distribution scheme.[28] The prospects for reallocation under block grants are not good even without cuts. If social funding is a zero-sum game and choices are forced down to community or even state levels, small changes in dollars can mean significant cuts in services.

■ **Appoint a special commission.** Elsewhere in this volume, Nancy Adler and Katherine Newman cite the process used to compile the Acheson report in the United Kingdom as a possible model for the United States.[29] If effectiveness can be measured by actual policy actions, then the Acheson report has been effective. For example, the U.K. chancellor of the exchequer has announced a focus on deprived areas and is working with the prime minister and the ministers of health and social services on a cross-cutting spending review of health inequalities.[30]

■ **Establish a permanent locus of collaboration.** Commissions and special reports are by definition time limited. They can get the collaborative process started, but eventually intersectoral activity must be institutionalized. If the United States wanted to consider a locus of collaboration with broad purview, the responsibility could be lodged in a special congressional committee, or in the Office of Management and Budget or the Council of Economic Advisers. An alternative proposal is to create a new White House Council of Health Advisers to bring clout to intersectoral efforts.[31]

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■ **Involve states and communities.** Whatever the method of collaboration, decisions in the United States are made and health is ultimately affected at federal, state, and community levels. The wide variation in health measures among states has been linked not only to income inequality and poverty but also to low levels of participation and trust and to less generous investment in health and welfare. One hypothesis is that as the gap between rich and poor increases, the well-off have less of a stake in what happens to the rest of the population, and the states with the biggest income and health gaps are least likely to choose remedial action.[32] Conversely, the federal government may have much to learn from intersectoral efforts such as Minnesota's. For both reasons it is important to involve state and community representatives in the collaborative process and to cast a bright spotlight on health differences among states and communities, which are often greater than differences among nations.

RESEARCH ON THE socioeconomic determinants of health offers a rich array of policy options and areas for further exploration. Barriers to intersectoral collaboration can be addressed by sensitivity to long-held political beliefs, careful attention to the quality and relevance of research and its dissemi-

nation, outreach by health experts to other disciplines, and imaginative use of governmental institutions.

The authors appreciate the constructive suggestions of Len Nichols and Angus Deaton, who commented on an early draft, and two anonymous reviewers.

NOTES

1. See, for example, in *Health Affairs* (Mar/Apr 2002), N.E. Adler and K. Newman, "Socioeconomic Disparities in Health: Pathways and Policies," 60–76; A. Deaton, "Policy Implications of the Gradient of Health and Wealth," 13–30; M. Marmot, "The Influence of Income on Health: Views of an Epidemiologist," 31–46; and N. Lurie, "What the Federal Government Can Do about the Nonmedical Determinants of Health," 94–106.
2. B.G. Link and J. Phelan, "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behavior* (Extra Issue 1995): 80–94; and P.M. Lantz et al., "Socioeconomic Factors, Health Behaviors, and Mortality," *Journal of the American Medical Association* (3 June 1998): 1703–1708.
3. In favor of the material deprivation theory, see J.W. Lynch et al., "Income Inequality and Mortality: Importance to Health of Individual Income, Psychosocial Environment, or Material Conditions," *British Medical Journal* (29 April 2000): 1200–1204; and C. Muntaner, J. Lynch, and G. Davey Smith, "Social Capital, Disorganized Communities, and the Third Way: Understanding the Retreat from Structural Inequalities in Epidemiology and Public Health," *International Journal of Health Services* 31, no. 2 (2001): 213–237. In favor of the psychosocial interpretation, see R.G. Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996); and I. Kawachi et al., "Social Capital, Income Inequality, and Mortality," *American Journal of Public Health* 87, no. 9 (1997): 1491–1498.
4. D.R. Williams, "Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination," in *Socioeconomic Status and Health in Industrial Nations: Social, Psychological, and Biological Pathways*, ed. N.E. Adler et al., Annals of the New York Academy of Sciences, Vol. 896 (New York: NYAS, 1999).
5. See, for example, S.L. Syme and K.L. Frohlich, "The Contribution of Social Epidemiology: Ten New Books," *Epidemiology* (forthcoming).
6. In 2000 the National Policy Association and the Academy for Health Services Research and Health Policy sponsored a conference on the policy implications of research on socioeconomic factors and health. See J.A. Auerbach, B.K. Krimgold, and B. Lefkowitz, *Improving Health: It Doesn't Take a Revolution* (Washington: National Policy Association, 2000); and J.A. Auerbach and B.K. Krimgold, eds., *Income, Socioeconomic Status, and Health: Exploring the Relationships* (Washington: National Policy Association, 2001).
7. See D. Black et al., *Inequalities in Health: Report of a Research Working Group* (London: Department of Health and Social Security, 1980); and *Independent Inquiry into Inequalities in Health: Report* (London: Stationery Office, 1998). This report (known as the Acheson report) was followed in England by a national intersectoral health plan and local targets for health, including the full range of socioeconomic determinants. See J. Bull and L. Hamer, *Closing the Gap: Setting Local Targets to Reduce Health Inequalities*, November 2001, <www.hda-online.org.uk/downloads/pdfs/closing_the_gap.pdf> (13 November 2001). See also S. Macintyre and G. Hart, "Tackling Health Inequalities in Scotland: A Policy Relevant Research Agenda," *Perspectives on Policy* no. 3, January 2000, <www.strath.gla.ac.uk/synergy/policy/3.html> (26 November 2001); National Committee for Public Health, *Health on Equal Terms: National Goals for Public Health*, Final Report (Stockholm: Fritzes, 2000); *Reducing Socioeconomic Inequalities in Health*, Final Report and Policy Recommendations, Second Dutch Programme Committee on Socio-Economic Inequalities in Health SEGVII, March 2001; *Preparing the Strategic and Action Plan for Public Health* (Wellington, N.Z.: Ministry of Health, September 2001); and Ministry of Employment and Solidarity, France, <www.emploi-solidarite.gouv.fr/index.asp> (2 January 2002).
8. These include the Community Health Center program, combining health, social, and environmental services for roughly ten million persons; the Head Start early childhood development program; and various community programs of the Centers for Disease Control and Prevention (CDC).
9. Minnesota Health Improvement Partnership Social Conditions and Health Action Team, *A Call to Action: Advancing Health for All through Social and Economic Change* (St. Paul: Minnesota Department of Health, July 2001).
10. The National Institutes of Health's (NIH's) Office of Behavioral and Social Science Research, Center for Minority Health and Health Disparities, and other institutes fund research and training in the socioeconomic determinants of health. Private funding for research training is provided by the W.K. Kellogg and Robert Wood Johnson Foundations. The NIH has hosted two major conferences: "Socioeconomic Status and Health in Industrial Nations: Social, Psychological, and Biological Pathways," with the New York Academy of Sciences in 1999, and "Social and Cultural Dimensions of Health: Toward a Higher Level of Analysis" in 2000. In addition, see B. Smedley and

S.L. Syme, eds., *Promoting Health: Intervention Strategies from Social and Behavioral Research* (Washington: National Academy Press, 2001).
11. *Healthy People 2010 Objectives: Draft for Public Comment* (Washington: U.S. Department of Health and Human Services, Office of Public Health and Science, 15 September 1999).
12. G.A. Kaplan et al., "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways," *British Medical Journal* (20 April 1996): 999–1003.
13. N.A. Ross et al., "Relation between Income Inequality and Mortality in Canada and in the United States: Cross Sectional Assessment Using Census Data and Vital Statistics," *British Medical Journal* (1 April 2000): 898–902.
14. Auerbach et al., *Improving Health*, 16–17; and D. Duchesne et al., *Vital Statistics Compendium 1996 Catalogue 84-214-XPE* (Ottawa: Statistics Canada, November 1999), Tables 9.3 and 9.4.
15. A.V. Diez-Roux et al., "Neighborhood of Residence and Incidence of Coronary Heart Disease," *New England Journal of Medicine* (12 July 2001): 99–106.
16. G.A. Kaplan, "Economic Policy Is Health Policy: Findings from the Study of Income, Socioeconomic Status, and Health," in *Income, Socioeconomic Status, and Health*, ed. Auerbach and Krimgold, 137–149.
17. For example, in 1988 one study compared the cost of reducing neonatal mortality through several health interventions and one nutrition program, finding timely prenatal care to be the most cost-effective. See T. Joyce, H. Corman, and M. Grossman, "A Cost Effectiveness Analysis of Strategies to Reduce Infant Mortality," *Medical Care* 25, no. 4 (1988): 348–360. More recently, researchers have used the cost per quality-adjusted life year (QALY) to compare various health procedures as well as auto safety and prevention interventions. See J.D. Graham, "Risk in Perspective: An Investor's Look at Life-Saving Opportunities," *Harvard Center for Risk Analysis* 7, no. 1 (1999).
18. M. Drummond and G.L. Stoddart, "Assessment of Health Producing Measures across Different Sectors," *Health Policy* (September 1995): 219–231.
19. E. Brunner and M. Marmot, "Social Organization, Stress, and Health," in *Social Determinants of Health*, ed. M. Marmot and R.G. Wilkinson (Oxford, England: Oxford University Press, 1999).
20. D.P. Keating and C. Hertzman, *Developmental Health and the Wealth of Nations: Social, Biological, and Educational Dynamics* (New York: Guilford Press, 1999).
21. J.S. House and D.R. Williams, "Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health," in Smedley and Syme, eds., *Promoting Health*, 81–124.
22. Ibid.
23. Ibid.
24. See B. Lefkowitz and J. Todd, "An Overview: Community Health Centers at the Crossroads," *Journal of Ambulatory Care Management* (October 1999): 1–12; and M. Falik et al., "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers," *Medical Care* 39, no. 6 (2000): 551–561. For Bush administration policy, see "Transcript of President Bush's Message to Congress on His Budget Proposal," *New York Times*, 28 February 2001.
25. See Centers for Disease Control and Prevention, "Safe in the Community," 10 December 2001, <www.cdc.gov/safeusa/communit/safecomm.htm> (22 December 2001).
26. D.A. Kindig, "Value Purchasers in Health Care: Pioneers or Don Quixotes?" in *Value Purchasers in Health Care: Seven Case Studies*, ed. D.A. Kindig and A. Burness (New York: Milbank Memorial Fund, September 2001).
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28. J. Lomas and M.M. Rachlis, "Moving Rocks: Block Funding in Prince Edward Island as an Incentive for Cross-Sectoral Reallocations among Human Services," *Canadian Public Administration* (Winter 1997): 581–600; and G.L. Stoddart et al., "Implementing a 'Determinants of Health' Approach to Health Policy through Cross-Sectoral Reallocation: A Canadian Case Study" (Unpublished manuscript, for the Population Health Program, Canadian Institute for Advanced Research, 2001).
29. Adler and Newman, "Socioeconomic Disparities in Health."
30. Bull and Hamer, *Closing the Gap.*
31. P.R. Lee, presentation on Public Policies to Improve Population Health at Association for Health Services Research Annual Meeting, Los Angeles, California, 25–27 June 2000.
32. I. Kawachi and B.P. Kennedy, "Health and Social Cohesion: Why Care about Income Inequality?" *British Medical Journal* (5 April 1997): 1037–1040.